KANSAS
DEPARTMENT OF HEALTH AND ENVIRONMENT
KATHLEEN SEBELIUS, GOVERNOR
Roderick L. Bremby, Secretary

HELP

CP No _____

HOME HEALTH AGENCY COMPLAINT INVESTIGATION REPORT FORM
(Please attach additional sheets as needed.)

REPORTING AGENCY
Name: _____ Phone No.: _____
HELP
Address: _____ E-mail address: _____
(Street/PO Box) (City) (State) (Zip Code)

REPORTING PARTY
Name: _____
(Last) (First) (Middle initial) (Title/position)
HELP
Address: _____
(Street/PO Box) (City) (State) (Zip Code)
Telephone: (___) _____ (___) _____
(Work) (Home)

INCIDENT INFORMATION
Date of Incident (on or about): _____

Information upon which this report is being made is as follows: (Please include a specific description of the incident, including the date, time, and location of the alleged incident.)

PRINT

RESET

Name & Cognitive Status of Client(s) involved:

_____
_____
_____
_____

If injured, please describe:

Corrective Actions Taken by the Agency:

_____
_____
_____
_____
_____
_____
_____

Report made to law enforcement? ☐ Yes ☐ No Police Case # _____	Name and address of law enforcement contact

Attachments:

❑ Agency Investigative Report & supportive documentation.

❑ Nurse Aide Registry Verification if the alleged Perpetrator is a CNA &/or CMA

❑ List of witnesses and **Notarized** Witness statements from those individuals regarding abuse, neglect or exploitation by an agency staff member.

❑ Completed Alleged Perpetrator Information Form (if applicable)

Attestation Statement: I certify that all the information given is true and correct.

_____

Signature Printed Name Title Date

Please return completed form to: Mary Kabriel, RN, State Survey Manager,

KDHE, Bureau of Child Care and Health Facilities, 1000 SW Jackson, Suite 330, Topeka, KS. 66612-1365

State Survey Manager Use Only: Review of information has been completed. Onsite survey: Yes ❑ No ❑

_____

Signature **Date**

PRINT RESET

ALLEGED PERPETRATOR (AP) INFORMATION FORM

TO BE COMPLETED BY THE FACILITY

Facility:

City:

ALLEGED PERPETRATOR INFORMATION:

Name: _____
Last First MI Alias

HELP

Address:_____
Street/Box City State Zip Code

Telephone Number: ( ) _____ Soc. Security _____

Date of Hire:_____

AP Suspended? YES ☐ NO ☐ Date: _____ AP Terminated? YES ☐ NO ☐ Date: _____

CREDENTIALING/LICENSURE INFORMATION

Certificate or License No. _____
(Attach copy of certificate/license)

Type of **Certification** (check all that apply) NAT ☐ CNA ☐ CMA ☐ HHA ☐ AD ☐ SSD ☐ QMRP ☐
Other ☐

NAT = Nurse Aide Trainee I or II
CNA = Certified Nurse Aide
CMA = Certified Medication Aide
HHA = Home Health Aide
AD = Activities Director
SSD = Social Service Designee
QMRP = Qualified Mental Retardation Professional

OR

Type of **License** (Check all that apply):

ACHA ☐ RN ☐ LPN ☐ RPT ☐ OT ☐ LMHT ☐ LSW ☐ Other: ☐

ACHA = Adult Care Home Administrator
RN = Registered Nurse
LPN = Licensed Practical Nurse
RPT = Registered Physical Therapist
OT = Occupational Therapist
LMHT = Licensed Mental Health Technician
LSW = Licensed Social Worker

THIS SECTION FOR OFFCIE USE ONLY:

Case No: _____ Code : _____

The above-named perpetrator has been found to have:

State Survey Manager Signature: _____ Date: _____

CP Form 101-KDHE-HHA Revised 09/03

PRINT RESET